MRA Mecklenburg Radiology Associates

Neuro Interventional Surgery Consultation Form

Cuong Nguyen, M.D. Andrew Griffin II, M.D.

1900 Randolph Rd., Ste 602, Charlotte, NC 28207
Clinic 704-384-9654 Fax 704-384-3680

Referring Physician: _____NPI #: _____

Practice Name: _____ Referral Contact: _____

Office Phone #: _____ Fax #:

_____

Patient Information:

Patient's Name: ___

SSN: _____ Male/Female DOB: _____

Phone # (Home): _____(Work): _____(Cell):_____

Address: _____ City, State, Zip: _____

Diagnosis/Reason for Referral:

____Cerebral Aneurysm ____Intracranial Atherosclerosis ____Vascular Malformation

____Carotid Stenosis/Bruit ____Vertebral Compression Fracture ____Blood patch

____Chronic Axial Back Pain (intercept procedure) Other_____

Insurance: _____ID #: _____Grp #: _____

Required prior to patient's appointment

- **A copy of the front and back of the patient's insurance card(s).**
- **Authorization, if required.**
- **Fax recent office notes, lab work, and radiology reports at least 48 hours prior to the patient's appointment.**
- **Patient should bring a disk of images or actual films to the consultation if these were not performed at a Novant Health facility.**

Please contact your patient with the following appointment:

Date of Consultation: _____ @_____

IF YOU HAVE NOT RECEIVED A REPLY FROM OUR OFFICE WITHIN 24 HOURS AFTER FAXING THIS REQUEST PLEASE CALL US.